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November 7, 2016

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**WHOLE PERSON CARE DRAFT EVALUATION DESIGN FOR CALIFORNIA'S  
MEDI-CAL 2020 DEMONSTRATION (11-W-00193/9)**

Dear Mr. Fishman, Ms. Rashid, and Ms. Sam-Louie:

Enclosed is the Whole Person Care (WPC) program's Draft Evaluation Design Report for submission to the Centers for Medicare and Medicaid (CMS), per Special Terms and Conditions (STCs) Item 211 of California's Section 1115 Waiver *Medi-Cal 2020 Demonstration* (11-W-00193/9). The State will submit the Final Evaluation Design, per STCs Item 214, within 60 days after necessary revisions are made in response to CMS comments on the report. The State will provide updates on the programs' evaluation implementation to CMS in each of the quarterly and annual progress reports.

Mr. Eliot Fishman, Ms. Mehreen Rashid, and Ms. Henrietta Sam-Louie  
Page 2  
November 7, 2016

If you or your staff have any questions or need additional information regarding these reports, please contact Sarah Brooks at [Sarah.Brooks@dhcs.ca.gov](mailto:Sarah.Brooks@dhcs.ca.gov). Thank you!

Sincerely,



Man Cantwell  
Chief Deputy Director  
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Enclosure:  
WPC Draft Evaluation Design

cc: Ms. Sarah Brooks  
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## **Whole Person Care Evaluation Draft November 2016**

### **Introduction**

The overarching goal of the Whole Person Care (WPC) Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient- centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. Through collaborative leadership and systematic coordination among public and private entities, WPC Pilot entities identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes.

### **Strategies**

WPC Pilots include specific strategies to:

- Increase integration among county agencies, health plans, and providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries and develop an infrastructure that will ensure local collaboration among the entities participating in the WPC Pilots over the long term;
- Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries;
- Reduce inappropriate emergency and inpatient utilization;
- Improve data collection and sharing amongst local entities to support ongoing case management, monitoring, and strategic program improvements in a sustainable fashion;
- Achieve targeted quality and administrative improvement benchmarks;
- Increase access to housing and supportive services (optional); and
- Improve health outcomes for the WPC population.

### **Evaluation Design and Methods**

As part of the Medi-Cal 2020 waiver, the California Department of Health Care Services is required to conduct two evaluations of the WPC program. The mid-point evaluation is due one year prior to the expiration of the demonstration and will include data from program years 1 (as applicable), 2, and (to the extent possible) 3. The final evaluation will be completed no later than six months following the expiration of the demonstration. The mid-point and final evaluations will meet standards of leading academic institutions and academic peer review, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

The purpose of the evaluations is to understand the extent to which the WPC Pilot interventions:

- Improve coordination across participating entities including data and information sharing;
- Improve beneficiary health outcomes;
- Reduce avoidable utilization of emergency and inpatient services (ED, hospital and psychiatric inpatient);
- Increase access to social services;
- Improve care coordination across participating entities;
- Improve housing stability, if applicable.

The evaluation will also describe promising practices identified by the WPC pilots and components of them that will be sustainable post implementation.

## **Evaluation Design**

WPC is an ambitious pilot program that requires participating entities to work together across sectors, many for the first time. Given the complexity and newness of the program, the mid-point evaluation will focus on how counties are developing the communication, coordination, and service infrastructure across sectors to improve care for vulnerable populations. Additionally, the mid-term evaluation will explore how pilots are using the Plan-Do-Study-Act (PDSA) model, as required in the Special Terms and Conditions (STCs), to continually adapt and improve their WPC programs.

The final evaluation will build on the mid-point evaluation and explore how pilots are leveraging new infrastructure and lessons learned through continuous PDSA cycles to achieve early improvements in health outcomes. The final evaluation will also address how pilots plan to spread and sustain the achievements of the WPC program once the demonstration is complete, and make policy recommendations to advance the WPC model beyond 2020.

Both evaluations will highlight the perspective of beneficiaries participating in the WPC program. While the pilot is designed to change systems of care, it is ultimately intended to improve the lives of vulnerable Medi-Cal beneficiaries. Through the stakeholder interview process, the evaluator will gather beneficiary stories that reflect the experience of beneficiaries and the personal impact of the WPC program.

## **Data for the WPC Evaluation**

The WPC evaluation will use the data reported in the mid-year and annual reports by the WPC pilots. WPC reports will include baseline data and subsequent quantitative and qualitative data on pilot infrastructure, approaches to care coordination, data and information sharing infrastructure, services and interventions including housing services (as applicable), physical and behavioral health outcomes, PSDA efforts and lessons learned. The list of universal and variant metrics to be evaluated can be found in Attachment MM of the STCs. Furthermore, the evaluation will include descriptive statistics that reflect the socioeconomic status and demographic composition of those served by the WPC Pilots. Medi-Cal fee-for-service and managed care encounter data will be incorporated into the evaluation, as appropriate. These data will be used to assess improvements in health outcomes and changes in utilization. Lastly, evaluators will interview state staff, WPC Pilot Lead and Participating Entity representatives, Pilot participants, Medi-Cal managed care health plans, and other stakeholders.

## **Required Elements of the Mid-Point Evaluation**

### **I. Executive Summary**

- a. Goals of the WPC program;
- b. Summary overview of the WPC target populations, interventions and services, and structures of the WPC pilots; and
- c. Key findings, initial takeaways and lessons learned from the mid-point evaluation, with a focus on use of PDSA to make continual improvements and develop program infrastructure, services and interventions.

## **II. Introduction**

- a. Overview of the WPC program, program objectives and data sources being used for purposes of conducting the evaluation.

## **III. Target Population**

Describe the WPC beneficiary population, providing aggregate state level information and a pilot-by-pilot breakdown.

- a. Number of beneficiaries participating; active and those that have graduated or transitioned from pilot;
- a. Participant characteristics (e.g., demographics, physical and behavioral health diagnoses, baseline rates of ED/IP utilization, housing needs, jail involvement, etc.); and
- b. Description of how WPC pilots selected their target population, determined eligibility and if there have been any changes to this group over time.

## **IV. Program Structure**

How WPC pilots have structured their programs, including a profile on each program and key similarities and differences across the pilots. Specific components will include:

- a. Lead and participating entities, their roles and collaboration;
- b. Infrastructure, including governance;
- c. Overview of the types of care coordination infrastructure pilots have put in place, including navigation infrastructure, coordinated entry, common assessment tools used among participating entities, collection and use of social determinants data, increased access to social services, etc.;
- d. Overview of the types of data sharing infrastructure pilots have put in place, including bi-directional data sharing with managed care health plans and participating entities, use of health information exchanges, use of population management systems and predictive modeling, implementation of care and case management software solutions; and use of real time data sharing and notifications to improve health outcomes and coordination of services;
- e. Type of services and interventions, including differences in eligibility requirements for FFS/PMPM services;
- f. Types of incentive payments, Pay for Reporting and Pay for Outcomes, including to downstream providers;
- g. Housing pool information, if applicable; and
- h. Other local related efforts that may interact with and/or support WPC (i.e., health homes, DMC waiver).

## **V. Performance Measures**

Initial baseline data and subsequent year data (if available) on universal and variant metrics from Attachment MM, as well as pilot identified Pay for Outcome metrics:

- i. Health Outcomes Universal Metrics:
  1. Ambulatory Care - Emergency Department Visits
  2. Inpatient Utilization - General Hospital/Acute Care
  3. Follow-up After Hospitalization for Mental Illness
  4. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- ii. Health Outcomes Variant Metrics, as applicable:
  1. 30 day All Cause Readmissions

2. Decrease Jail Recidivism
3. Overall Beneficiary Health
4. Controlling Blood Pressure
5. HbA1c Poor Control <8%
6. Depression Remission at Twelve Months
7. Adult Major Depression Disorder (MDD): Suicide Risk Assessment
- iii. Housing Variant Metric, as applicable
  1. Percent of homeless who are permanently housed for greater than 6 months
  2. Percent of homeless receiving housing services in PY that were referred for housing services
  3. Percent of homeless referred for supportive housing who receive supportive housing
- iv. Pilot identified Pay for Outcome metrics, other than required universal and variant metrics

**VI. Lessons Learned and Beneficiary Stories**

Aggregate summary assessment of individual WPC narratives that describes key barriers, challenges, successes and lessons learned thus far from the pilot. A description of specific challenges pilots encountered and what measures they are taking to address these barriers.

- a. An overview of how the PDSA model was used to make continuous improvements over time, highlighting 1-2 pilot examples;
- b. Beneficiary stories that describe what changes have been implemented as a result of the WPC pilot and the extent to which these changes have impacted participants' utilization/engagement in care.

**Required Elements of the Final WPC Evaluation**

**I. Executive Summary**

- a. Goals of the WPC program and
- b. Key findings and lessons learned. Highlights of any particular changes since the mid-point evaluation.

**II. Introduction**

- a. Overview of the WPC program, program objectives and data sources that will be used for purposes of conducting the evaluation.

**III. Target Population**

Describe the WPC beneficiary population, providing aggregate state level information and a pilot-by-pilot breakdown.

- a. Number of beneficiaries participating; active and those that have graduated or transitioned from pilot;
- c. Participant characteristics (e.g., demographics, physical and behavioral health diagnoses, baseline rates of ED/IP utilization, housing needs, jail involvement, etc.); and
- d. Description of how WPC pilots selected their target population, determined eligibility and if there have been any changes to this group over time.

#### **IV. Program Structure**

How WPC pilots have structured their programs, including a profile on each program and key similarities and differences across the pilots. Specific components will include:

- b. Lead and participating entities, their roles and collaboration;
- c. Infrastructure, including approach to care coordination and data information sharing;
- d. Type of services and interventions, including differences in eligibility; requirements for FFS/PMPM services, use of more than one service/intervention at one time, duration of services, case load ratio, etc.;
- e. The effect that incentive payments, Pay for Reporting and Pay for Outcomes had on the implementation of services, health outcomes, data sharing and quality data reporting;
- f. Housing pool information, if applicable; and
- g. Other local related efforts and how they interact with and/or support WPC.

#### **V. Care Coordination:**

Determination of whether WPC pilots are improving coordination across participating entities including data sharing.

- a. Overview of the types of care coordination infrastructure pilots have put in place, including navigation infrastructure, coordinated entry, common assessment tools used among participating entities, collection and use of social determinants data, increased access to social services, etc.
- b. Highlight 1-2 pilots.
- c. Description of how continuous PDSA cycles were used to improve coordination among participating entities.
- d. Initial baseline data and subsequent year data (if available) on universal and variant metrics from Attachment MM that relate to care coordination:
  - i. Administrative Universal Metrics:
    1. Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team
    2. Care coordination, case management and referral infrastructure
  - ii. Pilot identified administrative variant metrics tied to care coordination

#### **VI. Data Sharing**

An assessment of whether WPC pilots are establishing the data and processes necessary to measure and begin to improve beneficiary health outcomes.

- a. Overview of the types of data sharing infrastructure pilots have put in place, including bi-directional data sharing with Managed Care Plans and participating entities, use of health information exchanges, use of population management systems and predictive modeling, implementation of care and case management software solutions; and use of real time data sharing and notifications to improve health outcomes and coordination of services.
- b. Highlight 1-2 pilots.
- c. Description of how continuous PDSA cycles were used to improve data sharing infrastructure among participating entities.
- d. Initial baseline data and subsequent year data (if available) on universal and variant metrics from Attachment MM that relate to care coordination:
  - i. Administrative Universal Metrics:
    1. Data and information sharing infrastructure
  - ii. Pilot identified administrative variant metrics tied to data sharing

## **VII. Performance Measures**

Initial baseline data and subsequent year data (if available) on universal and variant metrics from Attachment MM, as well as pilot identified Pay for Outcome metrics:

- i. Health Outcomes Universal Metrics:
  1. Ambulatory Care - Emergency Department Visits
  2. Inpatient Utilization - General Hospital/Acute Care
  3. Follow-up After Hospitalization for Mental Illness
  4. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- ii. Health Outcomes Variant Metrics, as applicable
  1. 30-day All Cause Readmissions
  2. Decrease Jail Recidivism
  3. Overall Beneficiary Health
  4. Controlling Blood Pressure
  5. HbA1c Poor Control <8%
  6. Depression Remission at Twelve Months
  7. Adult Major Depression Disorder (MDD): Suicide Risk Assessment
- iii. Housing Variant Metric, as applicable
  1. Percent of homeless who are permanently housed for greater than 6 months
  2. Percent of homeless receiving housing services in PY that were referred for housing services
  3. Percent of homeless referred for supportive housing who receive supportive housing
- iv. Pilot identified Pay for Outcome metrics, other than required universal and variant metrics

## **VIII. Services and Interventions**

Review the effectiveness of the various services and interventions.

- a. Comparative analysis of the effectiveness of the various services and interventions used in the pilots.
  - a. Impact of the services, including but not limited to: care/case management, housing/tenancy, mobile, outreach and engagement, mental health, substance use disorder, respite, recuperative, sobering center, and post incarceration or institution services.
  - b. Factors that may be considered:
    - i. Eligibility requirements for FFS/PMPM services
    - ii. Bundled services
    - iii. Beneficiaries receiving more than one service/intervention
    - iv. Duration of services
    - v. Case manager to beneficiary ratio
    - vi. Intensity of services: short and intense services vs long and constant
    - vii. Mechanisms of approach: All-inclusive vs Tiered bundles that lead to “graduation”, etc.
- b. Efforts that resulted in more appropriate use of care, reduced inappropriate utilization and improved health outcomes.
- c. Assessment of changes that were needed along the way (via PDSA cycles) to better address beneficiary needs, improve coordination among participating entities, etc.



- d. Description of how the various elements of WPC pilots (e.g. FFS, PMPM bundles, data sharing, etc.) worked together to support the whole person as they move along the continuum of care.
- e. Beneficiary stories that describe what changes have been implemented as a result of the WPC pilot and the extent to which these changes have impacted participants' utilization/engagement in care.

**IX. Lessons Learned and Sustainability**

Aggregate summary assessment of individual WPC narratives that describes key barriers, challenges, successes and lessons learned from the pilot.

- a. A description of specific challenges pilots encountered and what measures they are taking to address these barriers.
- b. An overview of how the PDSA model was used to make continuous improvements over time.
- c. Plans to spread and/or sustain achievements made through the WPC program, including how WPC might be integrated with other delivery system reform initiatives going forward.

**Evaluator Selection**

The State will contract with an independent entity and ensure that the entity is free of conflict of interest to conduct an evaluation of the WPC Pilots. The State will contract with an entity that does not have a direct relationship to the State of California, Department of Health Care Services (DHCS). A data use agreement will be included in the contract to allow for the sharing of data with and access to data by the independent entity for purposes of conducting the evaluation. The State will seek application(s) from interested entities that have been identified based on prior experience and expertise in analyzing the experience of the population and working with the data that would be analyzed. Proposals will be scored; if a minimal score is not achieved, the State will seek proposals from additional entities.

**Evaluation Timeline**

The State will submit the draft evaluation for the WPC Pilot on November 9, 2016 to CMS. CMS will subsequently provide comments on the draft evaluation within 60 days of receipt. California will then submit a final evaluation design within 60 days of receipt of CMS' comments.

The draft evaluation will be posted on the DHCS webpage for stakeholder review and comment upon submission to CMS. The final design will include a summary of stakeholder comments and questions. The mid-point and final evaluations will be made available to the public on the State's website.